DOCUMENT RESUME

ED 262 342 CG 018 577

AUTHOR Patros, Philip G.; Shamoo, Tonia K.
TITLE Children's Suicidal Behavior.
PUB DATE Apr 85
NOTE 20p.; Paper presented at the Annual Meeting of the National Association of School Psychologists (17th, Las Vegas, NV, April 8-12, 1985).
PUB TYPE Information Analyses (070) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Children; *Coping; *Depression (Psychology); *Family Life; Parent Child Relationship; Prevention; *Stress Variables; *Suicide
IDENTIFIERS Loss

ABSTRACT

Children's suicidal behavior is surrounded by controversy with no single theory to explain or assess vulnerable children. Since accidents are the leading cause of death among children it is possible that some of these deaths are suicides. Beliefs by parents and professionals that children are not capable of suicidal behavior are being disproved as researchers substantiate suicidal behaviors in children: toxic ingestion, hanging, jumping, running into traffic, and cutting or stabbing have been documented. The most common impetus to suicide is depression. In addition, certain family patterns are significant: the loss of a significant parenting figure before age 12, pathological communication between parent and child, and ineffectual coping models. Young children who engage in suicidal behavior often have an immature concept of death, and suicide is often the end point of manipulation. Suicidal children experience significantly greater life stressors than do other children. Suicide can be an escape from an intolerable living situation or from a perceived loss. Education should be the first step to prevention and intervention; ways to facilitate this process include: (1) educating teachers in identifying children who are depressed and need help; (2) educating parents about the warning signs of suicidal children; and (3) educating children in cognitive coping skills and how to deal with stress and depression. (NRB)

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# Children's Suicidal Behavior

Philip G. Patros and Tonia K. Shamoo

Southern Connecticut State University

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ABSTRACT

Children's suicidal behavior is surrounded by controversy with no single theory to explain nor assess those children who are the most vulnerable to suicide. With accidents as the leading cause of death among children there is the possiblity that some accidents were in reality suicides. Due to the incredulity of parents and authorities statistical information is sparse. In order to promote better understanding of children's suicidal behavior this 4article will focus on the dynamics of children's suicide, childhood depression, family patterns, and the child's concept of death.

# CHILDREN'S SUICIDAL BEHAVIOR

Philip G. Patros
Southern Ct. State Unv.

Tonia K. Shamoo
Southern Ct. State Unv.

Children's suicidal behavior has not only been a neglected area of research, it also has been surrounded with controversy. There is no theory to explain suicidal behaviors in children nor is there a means of assessing children who are the most vulnerable to suicide. That there is an upsurge in suicidal behavior of children and adolescents has been documented by Frederick (1978). Unfortunately statistical information is sparse for latency-age children partially due to the incredulity of parents and authorities that children can and do kill themselves. Since accidents are the leading cause of death among children it is possible that some deaths were suicides (Cornell, 1972). It is difficult to distinguish what was an accident and what was a suicide attempt, due to social, legal, and religious restraints. Families, and the children themselves, have tended to hide the fact that a suicide attempt was made. Often injuries from unsuccessful suicide attempts go unrecognized in the physician's office (Hodgmen & Roberts, 1982).

Cohen-Sandler and Berman (1980) estimated that 12,000

latency-age children are admitted each year to psychiatric hospitals for suicidal behaviors. Increases of suicidal children seen in psychiatric outpatient clinics have also been reported (Pfeffer, Conte, Plutchik, & Jerrett, 1980). Presently within the schools more depressed and suicidal children are coming to the attention of school psychologists and counselors. If these children go unrecognized, the risk increases for subsequent attempts and completion. Therefore early detection and intervention at the school level becomes strategically important (Shamoo & Patros, 1985).

In order to promote better understanding of children's suicidal behavior this article will focus on the dynamics of children's suicide, childhood depression, family patterns and the child's concept of death. In summary the symptoms of the suicidal child, aged 5 to 14 years will be reviewed.

DYNAMICS:

Shaffer and Fisher (1981) defined childhood suicide as a "self-inflicted death occurring before a child's fifteenth birthday" (p. 546). Suicidal behaviors were defined by Pfeffer (1980) as "thoughts or actions which may lead to death or serious injury of the child" (p. 705). Garfinkel, Froese, and Hood (1982) suggested that children used suicidal behaviors to draw attention to their conflicts. However many professionals believed that children were not capable of suicidal behavior. Gould (1965) postulated that children,

because of their size, strength, motor coordination, and access to needed material, were unable to plan and effect a suicide. These beliefs are slowly being disproved as researchers begin to substantiate suicidal behaviors in children.

Clinical studies have highlighted the variety of techniques that children used for their self-destructive acts. Methods such as toxic ingestion, hanging, jumping from heights, running into traffic, and cutting or stabbing have been documented (Ackeerly, 1967; Cohen-Sandler & Berman, 1982; Lukianowica, 1968; Pfeffer, Conte, Plutchik, & Jerrett, 1979). Injestion of medication as well as other toxic materials, e.g., roach spray, rubbing alcohol or even turtle food, is the most popular method of children over nine years of age, with younger children favoring jumping from buildings or running into traffic (Cohen-Sandler, Berman & King, 1982).

DEPRESSION:

The most common impetus to suicide is depression (Friedman et al., 1984). Yet there are some in the mental health field who feel that depression in very young children is non-existent as depression is a function of the superego. Since children's superegos are not well-developed they cannot suffer from depression (Rochlin, 1959). It has only been recently that the DSM-III (1980) has listed child and adolescent depression as a diagnostic entity.

Syndrome vs symptom are two views of childhood depression (Kovacs and Beck, 1977). The first view suggests that child and adult depressions are similar. This view proposes that there is an actual sadness within the child. There are feelings of low self-esteem, irritability, weepiness, poor school performance, hopelessness, sleep and/or eating disturbances, fatigue, somatic complaints, increased aggressiveness, and enuresis or encopresis.

The second view hypothesizes that depression is not expressed directly but is "masked". Depression is expressed behaviorally by various symptoms. Masked depression can be expressed in the classroom as boredom, restlessness, fatigue, problems with concentration and behavior, and complaints of illness. Indeed many of the so called "acting-out" behaviors or conduct disorders are signs of depression.

The question then arises, are all depressed children suicidal and if not, how does one distinguish a suicidal child from a depressed child? Cohen-Sandler, Berman and King (1982) have compared suicidal children, depressed children and children with other psychopathology. Their results are felt to be significant, since they found that not all depressed children are suicidal, and that it is possible to distinguish between children who are suicidal and those who are depressed without the suicidal ideation. Of the 100 symptoms evlauated in the study, only two were cautiously

felt to reflect the discrimination significance between suicidal children or depressed children. These two symptoms, depressed affect and threatening people, suggest both an internal/external felt aggression. The symptoms, per se, do not provide the necessary discrimination, but when used with a developmental history and stress data, prediction is enhanced.

In a more recent research study, Beck (1985) postulates that hopelessness is a significant factor in determining those people who are at high risk for suicide. Beck followed 207 patients over a five year period and found that of the 14 patients who committed suicide, 13 of them had high scores on a measure of hopelessness.

While Beck's study was with adults, Rosenthal and Rosenthal (1984) worked with suicidal preschoolers, ages 2 1/2 to 5 years. Comparing 16 suicidal preschoolers, with 16 behaviorally disordered preschoolers, Rosenthal and Rosenthal found that the suicidal preschoolers exhibited more nonsuicidal aggressive behaviors toward themselves, were more depressed, had a loss of interest, morbid ideas, were impulsive and hyperactive with running away behavior.

FAMILY PATTERNS:

Family patterns offer another opportunity to view children's suicidal behavior. Family patterns which are significant are the loss of a significant parenting figure

before age 12; communication that is pathological; and ineffectual coping models (Lourie, 1967; Pfeffer, 1981; Stanley & Barter, 1970).

The loss of a parenting figure before age 12 has a significant impact upon a child's susceptibility to suicide (Stanley & Barter, 1970). Family disruption whether from death, separation, or divorce, appears to create a sense of isolation within the child. The suicidal child feels as if he/she has no control over the environment. In a study by Topol and Reznikoff (1982) the adolescent with external locus of control, i.e., believing that the outcomes of events are due to outside forces, was more likely to engage in suicidal behavior. It is suggested that these adolescents see their families as unavailable, rejecting or even perhaps overprotecting. An interesting marker is that a parental death is more often a factor in adolescents who completed a suicide as opposed to adolescent suicide attempters who experienced a parental loss through desertion or divorce (Dorpat, Jackson, and Ripley, 1965).

An equally dramatic impact felt by the child experiencing the psychological loss of a parent. The psychological loss may stem from marital discord, violence, substance abuse, and medical and/or psychiatric illness. Suicide attempters' families have been found to have higher rates of medical and/or psychiatric illnessess, particularly

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substance abuse, as well as a history of suicide (Garfinkel, Froese, & Hood, 1982).

Findings by Pfeffer, et al, (1979) support the idea that suicidal children's parents are depressed and suicidal.These children appear to identify with their parent's depression and feel hopeless and helpless to alter their environment. While not discounting a genetic predisposition for an affective disorder and/or suicidal modeling by parents or close friends, the fact remains that there is an increased risk of suicidal behaviors for these children.

Pathological communication between parent and child creates a stress that could place the child at a high risk for suicidal behaviors. The ways that communication can be blocked or never even established are varied. Children whose parents are physically ill often will not share problems with them. They do not want to burden them but rather want to protect them. Children of psychiatrically ill parents develop communication skills that protect them from negative parental interactions (Garfinkel, Froese, & Hood, 1982). Unfortunately these communication skills are ineffectual and counterproductive for survival (Pfeffer, 1981). Ten year old Paul tried to jump out a window after trying to tell his mother that he had failed a test. He had tried to tell her that he hated himself and wanted to die. In addition whenever Paul's parents had talked of separating, Paul would cover his

ears or fight with his sister.

The "expendable child" concept is another form of a pathological communication pattern. Sabbath (1969) first postulated the hypothesis that the parent has a conscious and/or unconscious belief that the child is bad or is a burden. When such attitudes are conveyed directly and/or indirectly to the child, the child activates a wish to die. An example of this is seen from our own experiences. Richie was an unwanted 5 year old. He had been told repeatedly by his mother that he was a "bother" and was the cause for his father's desertion. If he was not around she "would be happy". Richie began to become very careless and had repeated accidents. Each accident became more serious until he finally succeded in ending his life in a "bike accident".

Children who experience their environments as non-supportive, unpredictable, or overtly hostile tend to develop characterlogical limitations. These characterlogical limitations keep the child from learning appropriate cognitive coping techniques. Several studies point out that rigidity in thought processes is related to suicide (Levenson, 1984; Patsiokas, Clum, & Luscomb, 1979). These deficits in cognitive problem-solving abilities result in maladaptive and even self-destructive coping strategies in highly stressful situations. Suicidal children make cognitive errors in overestimating the seriousness of their

problems and by not considering enough solutions to them. Going one step further, children with poor coping strategies are not able to effectively utilize intervention and interactions that may be offered to them. Garfinkel, et al (1982) found that in their study 63% of the subjects had previous contact with psychosocial services. Psychological autopsies of successful suicides indicated that there had been professional contacts made months prior to the completed act. Obviously, these contacts were not enough to alter the felt stresses.

Thus, the family pattern dynamics suggest that children who have a suicide proneness experience a higher pattern of family disruption before the age of 12, and that these disruptions could result in the establishment of pathological communication and ineffective coping strategies. When there is a culmination of stresses these factors can lead to suicidal behavior.

DEATH CONCEPT:

Young children who engage in suicidal behavior often have an immature concept of death. Piaget (1923) theorizes that at ages 6 or 7 the child believes that anything that is active is alive. At ages 7 to 11 years there is a congitive awareness of the finality of death, with a mature and cognitive interpretation of death occurring around the adolescent years.

Nagy (1959) in his studies with children ages 3 to 10, found that up until age 5 death is felt to be temporary. Death is personified, with an awareness that it is irreversible occurring between the ages of 5 to 9. Around the age of 9, death is viewed as occurring for everyone and is understood to be inevitable.

Young children appear to have a tenuous sense of reality or mortality. Death is often viewed as a sort of magical fantasy place. Often children feel that they will, after death, be able to hover invisibly over the scene. The child believes that he/she can observe the effects of his/her actions (Garfinkel & Golombek, 1974).

While the concept of the finality of death is not fully developed in the very young child the fact remains that children are engaged in suicidal behaviors for a variety of reasons. These reasons include conscious and unconscious fantasies, wishes, and fears.

Suicide is often the end point of manipulation. The child is attempting to manipulate another in order to gain love and affection, or to punish another, or to change an impossible situation (Bender & Schilder, 1937). These manipulation attempts, usually against the parents, are the child's effort to take control of a situation where there are feelings of vulnerability and helplessness (Jacobs & Teicher, 1969). "You'll be sorry when I'm dead," reflects the child's

magical thinking. It is the child's fantasy of his/her control and or punishment. This threat points out the child's limited comprehension of death's finality. There is the implication that the child will survive or be around to observe the effect of his/her actions (Garfinkel & Golombok, 1974).

Children will use suicide as an escape from an intolerable living situation. As mentioned previously, the youngster who has suicidal behavior has fewer inner resources to fall back on during stressful times, i.e., coping and communication strategies (Garfinkel, Froese & Hood, 1982; Levenson & Neuringer, 1971). In early adolescence especially, there is an intensity of all his/her feelings such as anger, sadness and helplessness. These children can see "no way out" except suicide. Their life experiences are not enough and often problem-solving methods were not learned.

Loss can also be a reason for suicide (Morrison & Collier, 1969). The loss need not be of a parent but could be that of a friend, a pet, or even an intangible loss such as status, or self-esteem.

To a child who fears a loss of status or of self-respect because a test was passed with a C instead of the usual A, the imagined loss is just as real as a death. A loss can occur when a child feels he/she has been let down by someone close on whom he/she has been depending (Crumley, 1982).

Whatever the loss, what emerges are strong feelings of hopelessness.

The "expendable child" uses suicide to stop being a burden to a parent (Sabbath, 1969). This is suicide for love. When love and need are not met, interpersonal intimacy is not successfully developed. This is another type of loss.

When a child's hostile perception of a parent is internalized, feelings develop that say to the child that he/she is bad and not a good person. This aggression turned inward is depression. Pfeffer (1981) has hypothesized that to a child, suicidal behavior is a last-resort mechanism to remove or to punish the negative self-perceptions.

Role reversal, where needs for nurturance of the parents are projected onto the child, seems to be a common occurrence in children with suicidal behaviors (Pfeffer, 1981). The parent demands that the suicidal child fulfil a role of providing gratification and protection to the parent. To maintain this pathological support is often too overwhelming. The child reverts to suicidal behavior to remove these stressors.

SYMPTOMATOLOGY:

The identification of high risk children remains a difficult task. Literature in the area indicates that a longitudinal perspective of a child's history and life stresses, along with the clinical interview, may be the most

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useful in improving our predictive capabilities.

Cohen-Sandler's study (1982) demonstrated that both symptoms and life history data can be reliable predictors of children who are suicidal. Symptoms of depressed affect and threatening behavior, when viewed with analysis of recurring patterns of stressors and losses, are significant discriminatory factors.

Core factors in the determination of youth suicidal behavior appear to be a loss of a love object before age 12, a dysfunctional family pattern which results in inappropriate coping skills, and ineffective communication patterns. Also suicidal children experience significantly greater life stressers than do other children. Children's suicidal behavior may be the culmination of stress that is combined with the above mentioned factors.

SUMMARY:

Suicide is often used as a distress signal. Researchers have agreed that it is more likely for children to have made an attempt to commit suicide, without intending to have completed that act than to have succeeded. The child feels driven to a desperate act to call attention to problems; problems which may have been overlooked or thought to be trivial. There is a definite ambivalence to their attempts at suicide, but previously broadcasted signals that were given were not heeded. Signals are always given prior to a

suicide attempt and may be very specific, such as making a will or giving away possessions. Other signals are changes in eating/sleeping habits, inability to concentrate, abrupt changes in personality, impulsiveness, slackening interest in school work and decline in grades, loss or lack of friends and for older children, alcohol and drug abuse (AAS,1980).

Children's suicidal behavior is fast becoming America's number one mental health problem. Educating parents and school personnel should be the first step to prevention and intervention. Ways to facilitate this process are to provide in-service training for teachers on identifying children who are depressed and need help; teaching children cognitive coping skills and how to deal with stress and depression; and educating parents through workshops as to the signals that their child might be sending (Shamoo & Patros, 1985).

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